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# Implementing quality standards for drug services and systems

A six-step guide to support quality assurance

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## Contents



## Acknowledgments


This guide draws upon a wide range of published sources and work previously undertaken for the EMCDDA. It also draws upon the 2018 country reports on quality assurance provided by the national focal points of the Reitox network. The guide was drafted by Annette Dale-Perera, with input from EMCDDA staff Nicola Singleton, Jane Mounteney and Marica Ferri.

## About this guide

This short document aims to provide a summary of the main issues that people engaged in the implementation of quality standards in the area of drug demand reduction need to consider. There are many sources of more detailed information and guidance on implementing standards. This guide seeks not to duplicate or replace them but instead to act as an introduction, providing links to the wider literature and presenting the key issues for those planning and managing these processes. Further reading and sources of more detailed information are provided at the end of this guide. There is also no single correct way to implement quality assurance processes, and the choice of approach depends on many factors, including timing, objectives and the availability of resources.

This publication is designed to assist people in choosing the best approach to suit their circumstances and to maximise the value of any quality assurance initiative. More concretely, it aims to provide a practical introduction to the area of quality standards and quality assurance mechanisms and the key steps involved in their implementation in drug services and systems. Starting with an introduction to quality standards and their role in the broader area of quality assurance processes, the guide then presents in more detail six important steps to be considered by those intending to use and implement quality standards whether at the local, regional or national level. These reflection steps are based on public health intervention models, building on diagnosis, intervention selection, assessment and evaluation, and also draw on the model promoted in *Health and social responses to drug problems: a European guide* (EMCDDA, 2017a) and *Evaluating drug policy: a seven-step guide to support the commissioning and managing of evaluations* (EMCDDA, 2017b).

While the primary audience for this guide is those responsible for commissioning, planning or providing quality assurance processes at the national or local level, it may also be of interest to recipients of interventions, service users or advocacy groups.

## Who can use quality standards and for what purpose?

There are a range of stakeholders who may be interested in implementing quality standards for drug demand reduction interventions. Some of the main ones and the uses they may have for quality standards are listed below.

**Commissioners, planners or funders can use quality standards to:**

- ensure that services and interventions meet quality requirements;
- monitor services and interventions to ensure ongoing compliance with quality and safety;
- ensure client or service user feedback is embedded into planning and provision;
- ensure staff providing services and interventions meet quality requirements and are competent, well-managed and supported;
- support services to embed quality assurance processes.

**Service providers can use quality standards to:**

- audit, monitor and demonstrate service quality;
- actively find and address areas for improvement;
- benchmark (if appropriate) minimal quality;
- identify training needs for staff members.

**Individual practitioners can use quality standards to:**

- be clear about the competence and practice required from them;
- recognise their qualifications, training and skills;
- ensure they are well-managed, supported and have professional development;
- contribute to a culture of continuous improvement.

**Recipients, clients, patients and their families and other stakeholders can use quality standards to:**

- gain knowledge about the quality of services or interventions they can expect;
- make more informed choices about which interventions and services to access (if quality assurance results are publicly available);
- use known mechanisms to raise concerns and complaints about interventions or services;
- engage and contribute to quality assurance and improvement.

**Certification, accreditation, licencing, regulatory and inspectorate bodies can use quality standards to:**

- licence, certify or register interventions, services or practitioners;
- ensure ongoing compliance with regulatory requirements through inspection or revalidation processes;
- identify abuse, unsafe and non-evidence-based practice, service deficits, as well as action required to improve – in line with the remit of the organisation;
- identify priority areas for quality improvement in health and social care.

## Types of quality standards that apply to drug-related interventions

Quality standards are developed and published to support services and systems improvement, and they can be general or specific, voluntary or mandatory, national or local. National standards or mechanisms may be countrywide or devolved to federal, state, local or city levels. Many types of quality standards can apply to drug-related interventions. These may include general standards, for example, standards that cover all aspects of a health or education system, or they may be bespoke and specific to drug treatment or drug prevention.

An analysis of country reports on quality assurance, provided by national focal points to the EMCDDA in 2019, indicated the vast majority of European countries have in place a range of standards that apply to drug-related interventions or services. In some countries, for example, standards are linked to service delivery and evaluations. In other countries, quality standards are a requirement for participation in competitions for service contracts, or they are used as instruments for service-level self-assessment.

Many different types of quality standards exist, and they are used for a variety of purposes, all linked to the improvement of systems or service provision. Some standards are requirements that need to be fulfilled to be accredited. They can regulate the physical space and the facilities where a service is provided. Others cover the outcomes that a service

### Definitions used in this guide

**Accreditation** is the process by which an institution delivering a service is independently assessed for quality against pre-defined criteria and standards, which are set by the accrediting body.

An **audit** is a systematic examination of an activity, process, data, records or environment.

**Certification** is the formal attestation or confirmation of certain characteristics of an object, person or organisation. This confirmation is often, but not always, provided by some form of external review, education, assessment or audit.

**Evaluation** is a process that critically examines a programme. It involves collecting and analysing information about a programme's activities, characteristics and outcomes. Its purpose is to make judgements about a programme, to improve its effectiveness and to inform programming decisions.

**Evidence-based intervention** is a concept imported from the medical field, where evidence-based medicine is defined as 'the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients' (Sackett et al., 1996). When applied to drug demand reduction, this refers to the use of scientific results to inform intervention decisions.

**Guidelines** are used to encourage the use of evidence-based interventions by providing practice recommendations that are based on appraisal, synthesis and grading of available evidence. Guidelines typically outline a plan of expected activity (which may be mandatory in some countries). They provide a guide to recommended practice, and may operate alongside standards, providing a benchmark against which to evaluate the quality of the services being delivered.

**Quality assurance** is a process which involves continuous monitoring and striving to improve quality and outcomes. The concept includes the assessment or evaluation of the quality of care; identification of problems or shortcomings in the delivery of care; design of activities to overcome these deficiencies; and follow-up monitoring to ensure effectiveness of corrective steps. Quality standards are one of the tools used in the quality assurance process. Based on the WHO definition, quality assurance systems in drug demand reduction focus on the extent to which drug-related interventions, services or systems improve outcomes.

**Quality standards** are principles and sets of rules, often set by recognised national or international bodies, that may be used to implement interventions. A quality standard may be described as a statement of expected requirements. It can refer to content issues, processes or to structural aspects. Typically, the standards proposed in the health field are evidence-based, and provide clear and aspirational, yet measurable, statements related to content, processes or structural aspects of quality assurance, such as environment and staffing composition.

or a system is expected to achieve, the processes that should be implemented and the physical spaces where those processes take place. Some include recommendations for actions (and in this, they are similar to guidelines) and others are composed of aspirational statements to be operationalised in different contexts. Examples of formal or required standards include fire safety or infection control in drug use disorder treatment service premises; standards relating to staff qualifications or certification; national requirements to meet legislation to protect children and young people deemed at risk of harm; medicines management standards.

## Quality standards in the national, European and international context

The development and implementation of quality assurance in drug demand reduction is a priority in many European countries, and recent years have seen an increase in the proportion of countries that report having published guidelines and standards for interventions, and having set up accreditation systems for service provision.

At the European level, the European drug prevention quality standards (EDPQS), developed by the European Prevention Standards Partnership, were published by the EMCDDA in 2011. The Partnership reviewed, synthesised and consulted on existing evidence and standards in order to identify which quality standards should apply to drug prevention activities.

Quality standards in drug demand reduction have also been a priority in the last two EU drug strategies and related action plans. The actions in the European drug strategy 2013-2020 included a 'study on the development of an EU framework for minimum quality standards and benchmarks in drug demand reduction' (European Union, 2012). The EQUS project (Uchtenhagen and Schaub, 2011) developed a range of minimum quality standards for the European Commission, a selection of which were adopted in 2015 (see box below). The current EU drug action plan, 2021-2025 (European Union, 2021) calls, in Action 38, for services to be guided by the minimum quality standards for drug demand reduction interventions in the European Union. This publication is in response to that call.

The Cooperation programme between Latin America, the Caribbean and the European Union in drugs policies (COPOLAD) has developed a set of quality standards and criteria for drug demand reduction interventions, services and programmes (prevention, treatment, harm reduction and social integration) and elaborated them in collaboration with the EMCDDA, the Inter-American Drug Abuse Control Commission (CICAD), the Pan American Health Organisation (PAHO) and the United Nations Office on Drugs and Crime (UNODC).

### European minimum quality standards

The EU minimum quality standards (Council of the European Union, 2015) include 16 aspirational statements, allowing space for Member States to set their objectives and make progress at their own pace towards common goals. Countries are encouraged to operationalise them in line with their national strategies, and many interventions currently delivered at European or national level are based on the implementation of these standards. For example, for prevention, the standards clarify how the target population defines the type of prevention strategies to be put in place, and suggests that the analysis of the needs of these populations assists the selection of the most appropriate approach. The standards highlight the crucial role of training to build competences for professionals delivering prevention interventions. For treatment and social reintegration, the standards reinforce the centrality of patients and the need to respect their stage of preparedness for change as a basis to determine therapeutic approaches. In addition, the standards aim at ensuring voluntary access to treatment to all in need without any financial restrictions. To support the implementation of these quality standards, the European commission tasked the Civil Society Forum on Drugs with the publication of guidelines and recommendations for implementation, which was published recently (Civil Society Forum on Drugs, 2020).

At the international level, the UNODC and World Health Organization (WHO) have supported the development of quality standards for both drug prevention and treatment. Their 'International standards on drug use prevention' (UNODC and WHO, 2018) describe evidence-based prevention interventions and policies, and the major components and features of an effective national drug prevention system. The UNODC/WHO 'International standards for the treatment of drug use disorders' focus on the provision of guidance and training to health professionals on developing standards and accreditation for services at the domestic level, to ensure that responses to drug use disorders are scientific and evidence-based and are delivered by qualified personnel. The UNODC developed and piloted quality assurance mechanisms for drug use disorder treatment for services and systems (Saenz et al., 2019), and following global field testing, the UNODC/WHO 'International standards for the treatment of drug use disorders' were revised and relaunched in 2020, together with a suite of quality assurance tools.

## The quality standards implementation process

An overall goal of quality assurance is to create a cycle of continuous reflective practice and improvement. In this context, quality assurance mechanisms encompass the whole array of activities and documents that may be put in place to support the quality of interventions. In addition to quality standards, these may include, for example, evidence-based guidelines, paper or electronic checklists and reminders, training, inspections, audits and feedback, and surveys of client satisfaction.

Quality assurance mechanisms, including the use of quality standards, can help ensure that organisations are implementing or providing 'best practice' for patients, clients, staff and communities. Good quality drug demand reduction interventions, based on evidence and firmly located in human rights and 'best practice' can help improve people's lives and life chances. Quality standards, professional training and the overall quality assurance mechanisms can help all of those involved in drug demand reduction have clear expectations of what will be provided, from planners and funders, to providers and those receiving interventions. However, drug-related interventions are not neutral, and those which are not based on evidence risk being ineffective and producing unwanted effects.

Similarly, it is widely accepted that staff lacking competence (qualifications, skills or knowledge) are likely to deliver poorer outcomes in a drug demand reduction initiative. Quality assurance processes can help expose and tackle abuse or maltreatment of clients or service users, unsafe or dangerous practice, non-evidence-based practice and organisational deficits that compromise service delivery.

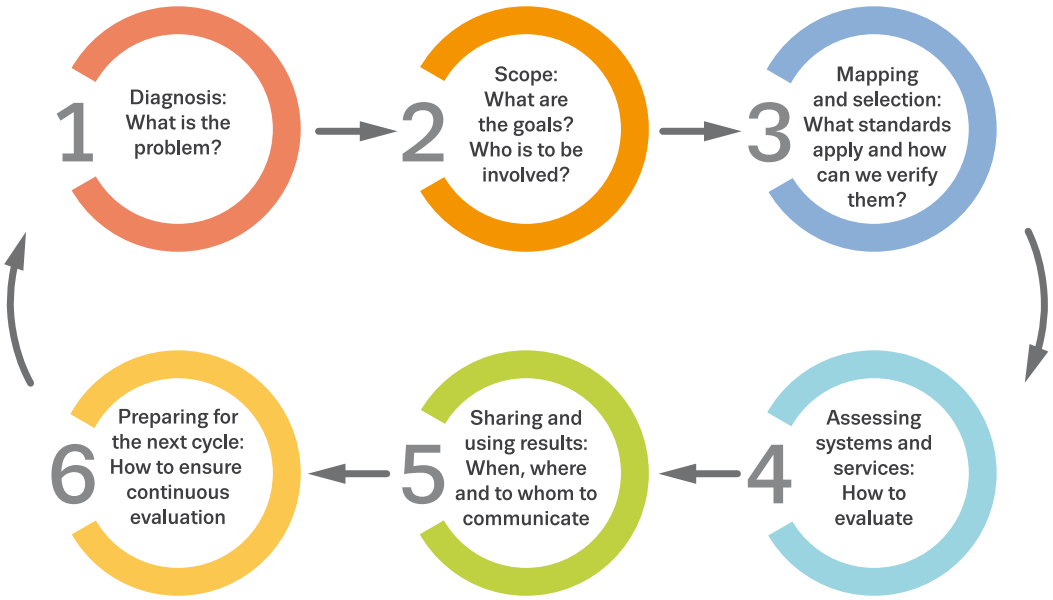
One of the functions of quality assurance is embedding a culture of reflection and continuous improvement. However, quality assurance mechanisms are sometimes seen as additional bureaucratic activities for already busy individuals, services or systems. In reality, they do require additional work but, in the long run, they help professionals to work better and to improve practices and services. Quality assurance mechanisms encourage 'user involvement', transparency and accountability and are proven methods of embedding effective practice.

## Six steps to consider for implementing quality standards

The following section proposes six steps to consider when implementing quality assurance processes and standards. Depending on the scope of the quality standards project, some or all of the steps may be helpful; nevertheless, taken together, they outline a full cycle of continuous improvement. However, it is also possible to start at different points in the cycle, and especially for those already engaged in a quality assurance process, certain steps may already be complete. Similarly, some steps may be more or less important for different types of assessment, depending on whether the focus is, for example, a harm reduction intervention, a treatment service or a prevention system.

1. Diagnosis: what is the problem?
2. Scoping: what are the goals and who to involve?
3. Mapping and selection: what standards apply and how can we verify them?
4. Assessment of systems and services: how to evaluate.
5. Drafting a plan and disseminating results: when, where, and to whom to communicate.
6. Preparing for the next cycle: how to ensure continuous evaluation.

FIGURE 1
**The six key steps to implementing quality standards**



# STEP 1

# Diagnosis: what is the problem the quality assurance project will address?

The initial diagnosis phase focuses on the identification of the problem that the quality assurance project will address. The problem diagnosis may use a range of analytic methods including analysis of service outcomes, the results of a client consultation (service level); the evaluation of a drugs strategy or a national health system performance (system level).

Important questions here might include: What needs is the project responding to? What is it trying to achieve? Is there is a need for improvement in a particular service area or system?

Some possible answers are:

- we need to respond to a problem (e.g. a service is outdated, does not attract young clients);
- we need to improve service outcomes (e.g. reducing waiting lists, reducing drop out, improving compliance);
- we need to pilot a quality assurance mechanism for a service;
- we need to assess whether a programme has been correctly implemented;
- we need to improve an existing quality assurance mechanism in an intervention, service or system;
- we need to benchmark interventions against each other in relation to their quality.

In some, hopefully rare cases, a quality assurance project can be initiated because there are complaints or concerns around serious issues, including for example abuse of clients or staff, or national laws being broken, or breaches of codes of professional practice. These cases can be the triggers for starting a process or may be discovered during the process. In both cases, immediate action may need to be taken. It is good practice to have a written protocol of actions to be taken if these issues are found, which is shared with the intervention, services or system managers prior to an assessment. If serious infractions are found, these have to be reported to the appropriate entities.

## What 'level' does the quality standards project relate to?

During the initial diagnosis step, it is also important to have clarity about which level the project relates to. In other words: what is the level of the problem identified and that

the quality standards project will need to address? A framework was introduced with the European EQUS project (Uchtenhagen and Schaub, 2011), which outlined quality standards at the levels of intervention, service and system.

The intervention level may include, for example, a psychosocial treatment such as a cognitive behavioural therapy programme or a drug prevention intervention. The service level might be, for example, an organisation providing a range of interventions such as a community drug service. System level could include, for example, a network of drug harm reduction, treatment and recovery services in a particular locality such as a city.

It is important that the level of the quality assurance project matches the remit of the services or people involved. For example, service providers who want to examine quality issues associated with access to treatment should focus on the issues they control, such as waiting times or equality of access for the populations they serve. They are not responsible for access issues for the whole system.

# STEP 2

# Scoping: what are the goals and who to involve?

Once there is a diagnosis of the problem and the needs to be addressed by the quality standards project are clarified, scoping will drive decisions on what leadership is required, who needs to be involved as key stakeholders, and the resources needed for the project. This step should conclude with the development of a concrete project plan.

## Leadership

It is critical to success to have good leadership for the project at a sufficient level of responsibility. The project leadership will need to ensure good planning and project management; governance; permission or consent for the process; and fairness and transparency, particularly as resistance or challenge may be encountered. Project leaders will need to involve and motivate the partners (service manager, intervention manager or system leader), not least because they are likely to be responsible for improving the quality of their intervention, service or system. Projects may benefit from a project management team or steering group involving key stakeholders, including senior representatives, clients or 'end participants' of the interventions, services and systems.

## Key stakeholders

Stakeholder involvement is central to quality standards implementation. Stakeholders have different roles, levels of responsibility and may be involved in a number of ways, including involvement in the project management group or a project steering group; through consultation processes on standards and criteria or development of an assessment methodology; by participating in an assessment process itself (for example as subjects, assessors, expert patient or peer interviewers); as recipients of results; or by being expected to change their practice to make improvements. Key stakeholder groups may include policymakers, planners and funders; service provider staff; recipients, clients or patients; partner services and organisations; and, wider carer and community stakeholders.

Table 1 shows the stakeholders that may need to be involved at different levels.

TABLE 1

**Stakeholders who may need to be involved**

| Intervention level | Service level | System level |
|---|---|---|
| • Clients or patients<br>• Patient advocacy body<br>• Intervention manager, staff<br>• Host service management<br>• Intervention funder or planner<br>• Staff 'professional' body | • Clients or patients<br>• Patient advocacy body<br>• Carers, community representatives<br>• Lead clinician, staff<br>• Staff 'professional' body<br>• Service manager, management body representatives<br>• Partner services<br>• Service funders or planners<br>• Service regulatory, accreditation or inspectorate body | • Clients, patients, carers<br>• Patient advocacy body<br>• Service representatives<br>• Epidemiologists, researchers<br>• System planners<br>• System funders<br>• Government officials, politicians, policymakers |

## Resources

Adequate resources for the project should be secured and allocated against the project plan, whether the project is small (for example, a review of what quality standards apply to a service) or large (for example, a pilot project for a new process implemented in a range of services). It is important that the project has a realistic budget for its actions. Most projects separate the resources required for the evaluation phase from resources required if improvement action is required: this should be clear from the outset. While the availability of resources may vary greatly, depending on the country or context, it is important to remember that it is always possible to address and improve the quality of interventions.

## Project planning

Once the scope is decided and the resources are secured, a detailed project plan should be developed. This may include aims, outcomes, desired outcome, project management arrangements, resources and a budget, the key steps with measurable milestones, who is responsible for each step and reporting arrangements/communications. It is important to allocate sufficient time for each step, as aspects of the project may be reliant upon other parties, for example, gaining ethical permission for assessments. Complex projects may also benefit from contingency and risk management plans. The project plan should be agreed upon with the project group and shared with key stakeholders.

# STEP 3

# Mapping and selection: what standards apply and how can we verify them?

At this stage, both the needs and scoping of the project are clear, and a project group has been set up to work on the implementation of quality standards. The next step is to decide which quality standards are most appropriate to use in the circumstances. As mentioned earlier, many quality standards are available for different purposes.

A country or locality may have existing quality standards and mechanisms that apply to their staff, interventions, services or systems. Some of these standards are voluntary, as is the case for the European and international standards but others, especially at local level, may be mandatory. Exploring existing quality standards and mechanisms that might be applicable is a key step in establishing a quality assurance mechanism.

## Types of quality standards to consider

There may be numerous sets of quality standards that are potentially relevant for drug demand reduction interventions. Most countries will have some standards or quality assurance mechanisms that are applicable. These may include general standards or quality assurance mechanisms, for example, standards that cover all aspects of a health system or education provider standards, or they may be bespoke and specific to drug demand reduction. The range may include:

- internationally recommended standards, such as the UNODC/WHO and European initiatives described earlier;
- national standards or mechanisms, or those devolved to more local areas such as federal, state or provincial requirements;
- standards or quality assurance mechanisms required as a condition of funding, for example, those required to receive state or health insurance funding;
- requirements from state or regional accreditation, certification, licensing, registration or regulatory bodies;
- standards or quality assurance mechanisms related to the type of service or delivery base of the intervention, such as standards for all hospital-based services, school-based interventions, standards for residential rehabilitation units;
- standards related to human resources and staff, which may be funding requirements, legal requirements, or professional body standards such as qualifications/certification;

- statutory or legal requirements and standards related to certain types of activities, such as financial conduct 'rules', health and safety standards and medico-legal standards (for example consent);
- voluntary standards and quality assurance mechanisms which may have formal recognition (such as the ISO standards and 'kite marks') or are a basis of internal audit.

Table 2 can be used to map and document which existing quality standards and quality assurance mechanisms may be relevant to your project.

TABLE 2
**Mapping quality standards and quality assurance mechanisms relevant to the project**

| What quality standards and quality assurance mechanisms apply to your project? | | | | |
|---|---|---|---|---|
| | Generic | | Drug-specific | |
| | Optional | Required/ formal | Optional | Required/ formal |
| International/European | | | | |
| National | | | | |
| Regional/local | | | | |
| Funding-related | | | | |
| Service-type specific | | | | |
| Setting-specific | | | | |
| Intervention-specific | | | | |
| Target group | | | | |
| Staff/professional body | | | | |
| Other | | | | |

# STEP 4

# Assessment of systems and services: how to evaluate

After having identified needs and having decided on the scope of standards implementation and having mapped the existing or suitable standards, and chosen those most appropriate, it is possible to proceed towards the assessment of services or systems (Step 4). This step consists of checking whether a system or a service meets the standards selected or needs to be improved. A key element to successfully completing this step is establishing consensus on the data required and choice of verification method.

## Deciding what information is required

It is advisable to carefully consider the information required for assessment of each quality standard or criterion that has been selected. Common forms of data utilised for assessing quality against standards and criteria in drug demand reduction interventions include the following.

- **Service or programme documents:** such as manuals, policies, procedures, protocols for interventions, planning documents, financial documents or accounts, service information, client or consumer information in order to document and measure the processes in place.
- **Monitoring, performance or outcomes data:** such as data on access, for example waiting times or the number of people on a waiting list, number of people or clients receiving a particular intervention or services, key indicator data; outcome data; patient or client complaints data; monitoring data on serious incidents or 'never events'.
- **Client or service user feedback:** such as data on satisfaction, the quality or appropriateness of an intervention; feedback on staff competency at delivering an intervention or the quality of a therapeutic relationship; feedback on environments or setting; suggestions for improving interventions or services.
- **Staff or manager feedback:** on issues such as staff and managerial competence (skills, knowledge and qualifications), training required, service or intervention delivery, suggestions for improvement.
- **Information collected by audits:** such as patient records or case note audits, staff record audits, audits of compliance with medicines management standards.

- **Feedback from key stakeholders**: such as organisations operating in partnership with the service being assessed, funders, members of the public or community groups with an involvement in the services or intervention, carers or those with parental responsibility for clients or recipients of interventions.

## Selecting the methods for data collection

Once a project group has reviewed what data it requires to review each quality standard, decisions should be made about the methods for collecting each piece of data. A range of methods may be used to collect and collate or analyse data for a quality assurance project. Common methods are:

- review of a documentation;
- collating and analysing service monitoring or performance data;
- client or service user surveys or focus groups;
- interviews with service managers;
- staff surveys or interviews;
- visual inspections;
- observations of intervention delivery;
- surveys or focus groups with key stakeholders.

Supporting information is generally either gathered by an external team or by the service or organisation itself (management or clinical or administrative staff tasked with a quality assurance role).

If the process is implemented by the organisation itself, the steps below may be followed.

- Ensure ethical approval requirements have been met and written consent forms accompany surveys (where required).
- Train assessors in the quality assurance process; gaining consent; data-collection in line with methods used and initial scoring. It may be helpful to create an 'expert assessor or audit team' to build organisational capacity in quality assurance, if this is undertaken by more than one person.
- It is good practice to create and distribute communications materials about the quality assurance process (including the standards that should be met) for key stakeholders – particularly clients or end-users and staff.
- Gather data according to the plan and resources.
- Collate information and data in a format that allows standards and criteria to be scored.

Especially in the case of international standards that may consist of aspirational statements and are not accompanied by sources of data and indicators of achievement, this step will consist of operationalising the standards in order to assess whether they are met or not.

TABLE 3
**Example of a standard, criteria and data taken from international consensus standards 2020**

| Standard M6: The service has a patient records system that facilitates treatment and care | | | | |
|---|---|---|---|---|
| **Ref** | **Criteria** | **Requirement** | **Scoring** | **Verification** |
| M6a | The service has a comprehensive patient record system | Paper or electronic patient record system | Met | Comprehensive paper/ electronic patient record system |
| | | | Partially met | Partial paper or electronic patient record system |
| | | | Not Met | No paper or electronic patient record system |

## Verification and scoring

Various possible ways are viable to assess the standards implementation; some are more rigorous and complex than others. Verification tools are available to support this step. These tools allow assessment as to whether a system or a service has already met the standards or if further actions are needed to improve the quality. Simple verification tools, for example based on Excel spreadsheets, can be used to compare data currently recorded (see the example in Table 3).

More complex verification tools can use some scoring systems where different levels of implementation are attributed different scores, these can use numerical or colour schemes. One possible verification tool is a 'scoring framework' using measurements methods. There are many examples of scoring frameworks in quality assurance mechanisms in both mainstream and drug use disorder treatment and prevention systems. Many frameworks use colours or numbers which are understood by many cultures and countries. Some frameworks have more granularity – such as a 5-point Likert scale that allows for a greater variety of scoring responses (see Table 4).

This is an area which requires some careful consideration by the assessment team. The choice of the verification tool should be influenced by the level of sophistication and resources available to the project, and should be clear and unambiguous. Whatever

TABLE 4
**Examples of scoring frameworks**

| Framework | Scale | | | | | |
|---|---|---|---|---|---|---|
| 3-point Likert scale | | Not met | Partially met | Met | | |
| BRAG scale blue, red, amber, green | Not applicable | Not met | Partially met | | Met | |
| 5-point Likert scale – descriptive | | Very poor | Poor | Fair | Good | Excellent |
| 5-point Likert scale – numeric | | 1 | 2 | 3 | 4 | 5 |
| Care Quality Commission | | Inadequate | Requires improvement | | Good | Outstanding ★ |

technique is used to establish scoring, it is essential that there is clear guidance on how to proceed. This is important for both the service, intervention or system being assessed and for the assessors.

## Important considerations during the assessment phase

Whether compliance with the selected quality standards has been evaluated internally or by an external partner, a good and constructive communication flow between the assessors and those being assessed is critical. Needs for improvement have to be seen as opportunities for all – both clients and professionals – rather than as judgement or blame for the professionals only. Although the managers of the intervention, service or system being assessed will ultimately be responsible for quality improvement and will be asked to keep implementing a cycle of continuous improvement, this effort has to be perceived as a co-production for the common interest.

Apprehension and fear are normal reactions to scrutiny – particularly if that scrutiny may impact on people's jobs or work practice. If managers are fearful, feel 'blamed' for poor quality or are resistant to change, it may be more difficult to get them to embrace a culture of reflective practice and continuous improvement.

On the other hand, a culture of understanding and 'no blame' is more likely to encourage results to be accepted and responsibility to be taken for improvement. Assessors should be skilled in working with resistance and barriers and should encourage a culture of pragmatism and responsibility.

# STEP 5

# Drafting an improvement plan and disseminating results: when, where and to whom to communicate

Following assessment and scoring by the assessors, the results should be presented as a written report. Often these reports feature some 'scorecard' or a summary sheet of scores, using colours and numbers, that is easy to understand. Nevertheless, the most important part of the report is the recommendations for improvements. These need to be based on a dialogue with key stakeholders on feasibility and include concrete steps for improvements.

The results of the quality assurance assessment should be communicated to the managers of the intervention, service or system. If the quality assurance process is new or the results are poor or controversial, it may be beneficial to present and discuss results in a meeting. If urgent and serious issues have been identified during an assessment, a formal process should be triggered as soon as feasible to ensure these issues are addressed without delay.

In any case, it is considered good practice to allow those receiving the assessment report some time to digest the report and raise queries, suggest factual corrections or dispute aspects of the assessment. Most formal quality assurance mechanisms will not accept additional data after the assessment – as this may have been developed after the assessment. A clear process of dispute resolution is required, especially in formal quality assurance processes that may influence funding or service continuation.

The final report should be formally agreed upon among the stakeholders and the assessors, as it forms the basis of subsequent actions to improve quality. Ideally, the results of the assessment should be made available to staff and clients and all those affected by the intervention, service or system evaluated.

The report will need to be followed by an implementation plan of actions to improve or consolidate the quality standards.

## The improvement plan and actions for prioritisation

Normally, the areas for improvement are those judged as not meeting standards. Nevertheless, they cannot be automatically translated into actions, without a consensus on priorities. Managers should be aware that selection of areas for improvement would normally include prioritising those that are critical to upholding human rights, client safety, staff safety or treatment or areas that are required by law or professional practice guidelines. If there are many areas for improvement, prioritisation can help focus limited resources on the most important issues to address.

TABLE 5
**Example of standards scoring with actions for improvement**

| Standard M6: The service has a patient records system that facilitates treatment and care | | | | | |
|---|---|---|---|---|---|
| **Ref** | **Criteria** | **Requirement** | **Scoring** | **Verification** | **Actions to be taken (Step 5)** |
| M6a | The service has a comprehensive patient record system | Paper or electronic patient record system | Met | Comprehensive paper/ electronic patient record system | No further actions needed |
| | | | Partially met | Partial paper or electronic patient record system | Incorporate the missing parts into the system |
| | | | Not Met | No paper or electronic patient record system | Implement a recording system, if appropriate |

In addition, when discussing the results of the assessment with the stakeholders, it is important to identify the reasons for not meeting some of the standards. For example, a common issue is deciding whether a score is due to a lack of monitoring or recording of practice (for example a lack of detail in monitoring or patient records) or actual deficits in practice.

For purposes of documentation, decisions on new actions to be taken can be added to the verification tool (see example in Table 5). The improvement plan can also include specific details, such as the target or outcome of the improvement, the resources required for the improvement to be made, who is responsible, when the improvement target will be met and when the re-audit will occur.

The improvement plan should be as practical as possible, with SMART objectives (specific, measurable, attainable, relevant and timely). Setting dates for the re-audit to check for improvement is an important part of the process, which can be negotiated between the stakeholders and the assessors.

# STEP 6

# Preparing for the next cycle: how to ensure continuous evaluation

An overall goal for a quality assurance project is to enable a culture of continuous improvement to become embedded in services and systems. In this context, implementing one-off assessments will be of limited value in improving quality over a period of time.

The main focus for this final step is ensuring that a cycle or process of continuous evaluation is in place. This will involve planning and preparing for the next cycle of interventions.

Having a culture of reflective practice and continuous improvement is a fundamental part of most healthcare and social services delivery. This is often embedded through governance mechanisms. Clinical governance, for example, is a mechanism by which health organisations are accountable for continuously monitoring and striving to improve the quality of their services. This ensures that standards are met, there is adherence to evidence-based guidelines and that clinical excellence is encouraged.

A culture of reflective practice and continuous improvement is also a core requirement for many professional staff groups such as doctors, nurses, pharmacists and teachers. Most professional staff are required to meet and maintain some standards of practice, demonstrated through gaining qualifications or professional certification (training); they are duty-bound to engage in supervision and continuous professional development; and they are assessed or revalidated regularly by regulatory, accreditation or inspectorate bodies to ensure quality of practice.

Once the report is disseminated and plans for improvement are being implemented, it might be helpful to maintain momentum by convening all your stakeholders to provide an update on the ongoing process and initiate discussions on the priorities for the next round of quality assurance and review. It is very likely that the quality assurance cycle identified new needs, for example to invest more in training and knowledge sharing and the implementation of new technological solutions. As a result, a follow-up quality standards project may have a different focus to the current one.

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## Recent international quality standards publications


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## About this manual

This publication provides a practical introduction to the area of quality standards and quality assurance mechanisms and the key steps involved in their implementation in drug services and systems. The primary audience for this guide is those responsible for commissioning, planning or providing quality assurance processes at the national or local level. It may also be of interest to recipients of interventions, service users or advocacy groups.

## About the EMCDDA

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is the central source and confirmed authority on drug-related issues in Europe. For 25 years, it has been collecting, analysing and disseminating scientifically sound information on drugs and drug addiction and their consequences, providing its audiences with an evidence-based picture of the drug phenomenon at European level.

The EMCDDA's publications are a prime source of information for a wide range of audiences including policymakers and their advisors; professionals and researchers working in the drugs field; and, more broadly, the media and general public. Based in Lisbon, the EMCDDA is one of the decentralised agencies of the European Union.


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